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Development of a quality assurance program for Army optometry

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Abstract

Quality assurance (QA) has become an important aspect in monitoring the quality of care provided by health care organizations. Used initially as a method for monitoring inpatient care, QA is now firmly establishing itself in outpatient care. Results of an informal survey of Army optometry clinics demonstrated that modern QA procedures are not being fully utilized. Based upon the requirements of the Joint Commission on Accreditation of Healthcare Organizations and the Army, a comprehensive QA program was developed for Army optometry. This program included methods for the monitoring and evaluation of care, the peer review of medical records, and the measuring of patient satisfaction. Sample indicators, criteria, and threshold levels were developed. A patient satisfaction survey and all materials needed for data collection were also designed. The optometry QA program was tested successfully at a major Army medical center with minimal complications. This program, with only minor modification, would serve as a useful model for any optometry clinic interested in beginning a QA program.

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DEVELOPMENT OF A QUALITY ASSURANCE PROGRAM FOR ARMY OPTOMETRY

A Thesis Presented to Pacific University College of Optometry
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ABSTRACT

Quality assurance (QA) has become an important aspect in monitoring the quality of care provided by health care organizations. Used initially as a method for monitoring inpatient care, QA is now firmly establishing itself in outpatient care. Results of an informal survey of Army optometry clinics demonstrated that modern QA procedures are not being fully utilized. Based upon the requirements of the Joint Commission on Accreditation of Healthcare Organizations and the Army, a comprehensive QA program was developed for Army optometry. This program included methods for the monitoring and evaluation of care, the peer review of medical records, and the measuring of patient satisfaction. Sample indicators, criteria, and threshold levels were developed. A patient satisfaction survey and all materials needed for data collection were also designed. The optometry QA program was tested successfully at a major Army medical center with minimal complications. This program, with only minor modification, would serve as a useful model for any optometry clinic interested in beginning a QA program.

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CHAPTER 1. INTRODUCTION

Background

Excellence in health care has been a common goal for both patients and health care providers. The objective of every hospital department is to provide the highest quality care possible for the patients they serve. This has become especially true over the last decade with the increase in consumer awareness in all areas of medical care. Health care, as any service industry, is under pressure more than ever before to increase the quality of its service.

In the past, quality in industry has been relatively easy to determine. The number of bad bolts out of a lot of 1,000 bolts gives a quantifiable measure of the quality of the product. What constitutes "quality" in health care is not as straightforward. Although there is often disagreement among providers upon what exactly "quality" health care is, practitioners do agree that "quality" care is a goal they all need to work toward. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines quality patient care as "the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge."[1] For the purposes of this thesis, the JCAHO definition will serve as the definition of quality patient care.

The earliest attempts to monitor the quality of health care have been traced back to 1800 B.C. when physicians were required to lose a hand if a noble patient died or lost sight as a result of surgery.[2] Monitoring the quality of modern health care began in 1951 with the formation of the Joint Commission on Accreditation of Hospitals (precursor to the JCAHO). The Joint Commission was developed for the purpose of assessing the adequacy and quality of care in hospital facilities. By 1985 the Joint Commission was utilizing quality

assurance (QA) programs as ongoing systems for monitoring and evaluating the quality and appropriateness of care.

QA programs have gained momentum in the last several years for three fundamental reasons [3]:

1. The ineffectiveness of self-regulation for health care providers.
2. Dramatic increases in the number of patients covered by third-party payment programs.
3. As a method of controlling costs for the consistently increasing expenditures for health care.

During the early 1980's, the Department of Defense (DOD) came under intense criticism for the quality of its medical care.[4] One of the many initiatives to develop during this time period was the beginning of hospital-based QA programs that focussed on the monitoring and evaluation of medical treatment and on care providers. Although only selected medical and surgical cases were studied initially, the importance of QA as a performance monitor became apparent throughout the DOD medical system.

What exactly is QA? QA is "an administrative device used to monitor performance to determine whether it continues to remain within acceptable bounds."[5] The term QA in no way implies a standard of perfection or the complete elimination of an acceptable level of human error. QA activities are "designed to assist practitioners in modifying practice behavior found to be deficient by quality assessment, to protect the public against incompetent practitioners, as well as to modify structural or resource deficiencies that may exist."[6] Through QA programs, attempts are made to identify and resolve problems found in either the quality or appropriateness of care.

Literature Review

The majority of articles that have been published concerning QA in health care are in areas outside optometry. Many of the references reviewed for this paper covered QA practices in ambulatory health care settings [7-11], inpatient settings [12,13], small health clinic settings [14], and health maintenance organizations.[15,16] Less traditional approaches to QA programs were also found, among them QA programs using management-by-objectives [17], decision analysis [18], and industrial quality management science.[19]

Within optometry, QA has had a very brief history with only a handful of articles being published. In 1979, Levenson published an article in the Journal of the American Optometric Association (JAOA) warning optometry to prepare for the advent of QA programs.[20] Levenson felt that optometry could show its initiative and develop its own optometric QA programs, or someone outside optometry, whether a third party payer or the government itself, would soon undertake it. As Levenson stated, "we can no longer stand by our laurels and our professional integrity--not in today's consumer oriented market place."[21]

It was not until 1985 that the next article on QA, by Kirkpatrick and Shotwell, appeared in the JAOA.[22] Changes made by the JCAHO in 1984 had allowed some nonmedical practitioners capable of independent practice (among them optometrists) to join the medical staffs of hospitals. Kirkpatrick and Shotwell, both optometrists in the armed forces, tried to communicate the QA experience they had gained in the multidisciplinary practice setting of the military hospital to civilian optometrists in private practice.

By 1988, optometrists were beginning to address the quality of optometric care provided by third party vision plans. Whitener and Dworakowski-Howe wrote that health care was being transformed from a public

service into more of a well-managed business.[23] Cost efficiency, not cost effectiveness, was becoming the primary focus in health care.

The most current journal article on optometric QA was published in the JAOA by Marshall in 1989. He saw that the delivery of health care was moving away from traditional methods toward alternative health care delivery systems (i.e. health maintenance organizations, preferred provider organizations, etc), and he observed that managers of these alternative health care delivery systems seemed to have more of a "bottom-line" mentality. As Marshall stated, "the infusion of a 'bottom-line' mentality into the planning and implementation of health care programs has created major problems for the assurance and maintenance of quality care."[24]

In summary, several articles on optometric QA had reached the journals of professional optometry prior to 1990. These articles had a limited impact on the profession in general, and on Army optometry in particular. Few Army optometrists were utilizing modern QA procedures in their clinics.

Council on Clinical Optometric Care

One optometric organization that has had an impact on the quality of vision care for many years has been the Council on Clinical Optometric Care (CCOC) of the American Optometric Association (AOA). The CCOC was established in 1967 "to assure the public the highest standard and quality of vision care."[25] The CCOC was designed to evaluate health care, not in the private practice optometrist's office, but in the institutional setting (i.e. clinics, group practices, ambulatory care facilities, etc.).

Although developed to "establish and promulgate standards for clinical optometric care," the CCOC was never able to develop standards of care or practice guidelines.[26] The CCOC was successful at having institutional optometry stop, evaluate itself, and determine exactly what level of care was

being provided. Although modern QA techniques were not utilized until recently, peer review of medical records and the importance of measuring patient satisfaction were stressed by the CCOC. Over the past few years, as the JCAHO has widened its responsibilities into the outpatient setting, the importance of the CCOC as a quality monitoring body for optometry has decreased.

Current Status -- QA and Army Optometry

Modern QA methods are being overlooked by most Army optometry clinics. Between April and June 1990, an informal survey of QA programs in effect at twenty Army optometry clinics was conducted. The results of the survey showed that no optometry clinic had a complete QA program in place. Some clinics had no QA program whatsoever. Other clinics had QA programs consisting primarily of peer review and/or medical record audits. Those clinics having a QA program in place had developed that program locally without any standardized format and typically with minimal reference to JCAHO and Army regulatory requirements.

As a general rule, Army optometrists do not have a working knowledge of QA terminology. Developing indicators (measurable dimensions of the quality or appropriateness of care), and selecting threshold levels (pre-established levels of performance which, if not met, requires further analysis) is often done without the necessary background in QA methods. (Examples of indicators and threshold levels are found in Appendix A, pages C-1 to C-29). Most Army optometrists also do not realize that in setting up a complete QA program, the JCAHO's ten-step plan for monitoring and evaluating health care needs to be followed, peer review of medical records must be conducted, and patient satisfaction must be periodically measured.

Goals of the Project

The intent of this project was to develop a comprehensive QA program for Army optometry. A standardized QA program that explains current JCAHO and Army regulatory requirements and then provides a model optometric QA program consisting of a patient satisfaction survey, a peer review system, and the framework for monitoring and evaluating care would be extremely valuable to all Army optometrists.

Such a program would offer the following advantages:

1. Standardize QA throughout Army optometry so that as optometrists are transferred from one facility to another, they can adapt quickly to the QA program in place at the new facility.

2. Update all Army optometrists on current QA terminology and techniques, including the JCAHO's ten-step method of monitoring and evaluating health care, how to identify indicators, how to set threshold levels, and how to analyze trends to improve the quality of care delivered.

3. Improve the overall quality of health care provided by Army optometry by ensuring all practitioners practice above a minimum acceptable level of proficiency.

CHAPTER 2. DEVELOPING THE QA PROGRAM

Background

Following completion of the literature review on QA articles both inside and outside health care, several optometry organizations were surveyed for their use of QA programs. Communication with the American Optometric Association (AOA), the Indian Health Service, the Department of Veteran's Affairs, the Air Force, and the Navy yielded optometric QA programs varying in completeness and applicability. Some of the organizations had no centralized QA program (Navy and Department of Veteran's Affairs), while others (Air Force and Indian Health Service) had much more formalized programs in place. The optometry departments of three large health maintenance organizations were also surveyed for the completeness of their QA programs, but no optometric QA programs were found operating as of June 1990 when the survey was completed.

In addition to obtaining examples of the types of optometric programs currently in operation, the JCAHO's existing requirements for QA programs were reviewed. The JCAHO, as the accreditation body for health care, sets the standards around which all QA programs should be modelled. Whenever possible, guidelines provided by the JCAHO were followed in developing the QA program for Army optometry.

Appropriate Army regulations, among them Army Regulation 40-68 (AR 40-68), Quality Assurance Administration, were also studied for input prior to the development of the Army QA program.[27]

Monitoring and Evaluation Process

Effective QA programs are established based upon the JCAHO's ten-step method for monitoring and evaluating health care.[28] This method was followed as closely as possible in developing the monitoring and evaluation process for

the Army QA program. Portions of the monitoring and evaluation programs of other optometry organizations were also utilized whenever applicable.

In developing the monitoring and evaluation process for the Army QA program, twenty-five indicators were developed with their supporting criteria and threshold levels. Although current emphasis in health care evaluation has shifted from the development of process indicators to outcome indicators, clinical indicators were developed in all three categories suggested by Donabedian: structure, process, and outcome.[29] As Donabedian points out, there exists such a strong interrelationship between structure, process, and outcome that any assessment of the quality of care must be based upon indicators developed in each of the three categories.[30]

Indicators, criteria, and thresholds were determined based upon the best available information on standards of care and practice guidelines used by the profession. The actual indicators, criteria, and thresholds used during the sixty day test period at Madigan Army Medical Center (MAMC) were modified in consultation with the MAMC optometric staff to more accurately reflect that clinic's mode of practice. One of the difficulties in developing indicators, criteria, and threshold levels was the overall lack of nationally recognized optometric standards of care or practice guidelines.

In addition to developing the indicators, the method and frequency of data collection were determined. Whenever possible, sources of medical data were used that were already available. For optometry, this primarily consisted of the patient medical record. For other than the most serious of indicators, sampling of the available data allowed for the most efficient use of QA resources. The nonprobability sampling technique of quota sampling was utilized in gathering the data, with the JCAHO recommending sample sizes of not less than twenty cases or less than 5% of the expected patient population,

whichever is greater.[31] This conformed closely with the sampling guidelines recommended by the Army's Health Services Command (HSC), manager of the Army's medical services within the United States.[32] As Palmer states, "patient care evaluations are not research studies, and therefore, it is not necessary to aim at statistically significant findings."[33] Becoming bogged down with stacks of medical records waiting for review not only wastes QA resources, but becomes extremely discouraging for all those involved in the data collection process.

Frequency of data collection was determined by the expected number of patients falling within the area being monitored, the degree of risk to the patient in receiving the care, and the past record of problems associated with that care. Indicators with serious complications or that occured only infrequently would generally have every occurrence reviewed. Indicators that occurred more frequently or with less serious complications were reviewed at predetermined time intervals, such as monthly or quarterly.

Peer Review of Medical Records

Peer review of medical records is an ongoing, retrospective evaluation of the quality of care delivered by an organization. Where the monitoring and evaluation process focuses on a few selected indicators at any one time, the peer review process looks for shortcomings in numerous administrative and clinical areas during the same record review.

Peer review programs can be designed to operate with either explicit or implicit criteria. Even though not an ideal method for evaluating health care, peer review is an extremely important process. When it comes to determining the level of care provided by an organization, Donabedian sums up peer review by stating, "there is nothing we now have that can handle better the entirety of practice in all its rich variety and detail."[34]

The peer review conducted for the Army optometry QA program utilized implicit criteria based upon the great diversity in education and training of optometrists within the Army. Records selected for monthly peer review were identified randomly. Administrative review concentrated on appropriate documentation being achieved. Clinical review ensured that at least a minimum optometric exam was performed and that appropriate optometric care had been delivered. For each optometrist, a minimum of 10% or 25 medical records, whichever was greater, were identified for auditing monthly as recommended by HSC.[32] The Peer Review Record Sheet (Appendix A, page E-1) was developed to assist in the documentation of the peer review process.

Measuring Patient Satisfaction

Introduction

When a doctor manages an episode of illness for a patient, that doctor uses both the "art" and "science" of care in treating the patient.[35] The "science" of care consists of the technical aspects of care, and is measured with the structure and process indicators contained in the monitoring and evaluation process. The "art" of care is concerned with the interpersonal relationship between provider and patient, and is most commonly measured with patient satisfaction surveys. The survey is also useful in evaluating the patient's perception of their accessibility to care.

Patient satisfaction surveys have become a significant component of QA programs. As the emphasis on the assessment of health care has shifted over the years from structure to process to outcome indicators, patient satisfaction surveys have steadily increased in importance. Measurement of patient satisfaction gained prominence as a tool for evaluating health care when providers realized that medical diagnosis and treatment were greatly affected by accurate patient communication and active patient involvement in the care

process.[36] Patients were also found to be much more likely to accept and follow the instructions given to them by a doctor when they were satisfied with the care they had received from that same doctor.[36] Because of the importance patient satisfaction has played in the health care process, it has itself become a key outcome indicator.[37] The JCAHO has realized the importance of measuring patient satisfaction in ambulatory care by making it one of their required characteristics. The JCAHO has required that a "hospital gathers, evaluates, and takes appropriate action on information that relates to the patient's satisfaction with all aspects of the ambulatory care services provided."[38]

Patient Satisfaction Surveys

Surveys used in the gathering of patient satisfaction data have many of the same characteristics common to all surveys. Survey respondents (patients) must understand the justification for the survey (i.e. what the study is about, what benefit the survey will have, why the survey is important, etc.). If the patient feels the survey is unimportant, they will not spend time completing it.

The sample survey developed for this Army QA program (Appendix A, page F-1) was designed along what is called the inverted-funnel sequence, with the survey beginning with very specific questions and moving towards more general questions.[39] By answering specific questions first, the respondent was forced to formulate attitudes in a number of subareas before any overall point of view was reached. Within the survey, questions were grouped together so that all the questions on one topic were completed before changing to another topic. Surveys were designed as professional in appearance as possible. Crowding of questions to conserve space was avoided. Sufficient white space was present within the survey so that it appeared easier to complete, which in turn encouraged a higher completion rate.[39] Any questions

that might have been construed as threatening to the patient, as well as any open ended questions, were included towards the end of the survey.

Several formats were used for the questions utilized in the patient satisfaction survey. In addition to the Yes-No and multiple choice formats, there were also open ended questions and questions utilizing Likert scales. Because they are relatively easy to use and intuitively easy for survey respondents to complete, Likert scales are one of the most commonly used scales in social research.[40]

Selection of patients for completion of satisfaction surveys was done randomly. As the patient departed the doctor's examination room, those patients randomly selected to complete surveys were identified. Patients were explained the importance of the survey, and for what the results would be used. Patients were then directed to a private area in the clinic and allowed to complete the survey. Upon completion, surveys were stuffed into a "ballot-box" container to give the patient as much confidence as possible that the results would be anonymous. Survey completion in the clinic immediately following the patient's examination was utilized instead of mail surveys so that the survey response rate could be maximized. Telephone surveys could also have been used in lieu of the written surveys, although patient anonymity would then have been partially compromised.

The minimum number of patient satisfaction surveys to be completed annually was determined by calculations found in HSC Pamphlet 40-7-23, Appendix A.[41] The number of patients to be randomly selected by the optometry clinic was determined based upon the average daily number of patients seen by the entire hospital, and the average daily number of patients seen in the optometry clinic.

CHAPTER 3. QA PROGRAM TEST PERIOD

Methodology

Implementation of the devised optometric QA program was completed in a practice setting with multiple optometrists over a sixty day test period. The Optometry Service, MAMC, Fort Lewis, WA served as the test site.

Prior to the test period, optometric personnel at MAMC were briefed on what QA is, how QA programs operate, and specifically what was required of each person to run the program effectively. The Army Optometry QA Manual was reviewed so that the clinic staff understood what was needed to run a comprehensive QA program.

Initially, the MAMC optometric staff was somewhat hesitant on starting a QA program because they feared a large time commitment. The optometric staff was experiencing a turnover in personnel and their daily work schedule fluctuated widely secondary to activities related to Operations Desert Shield and Desert Storm in the Middle East. Because optometric staff time was critical, optometric technician support was utilized for the QA program whenever possible. Effective use of support staff allowed the optometrists to spend a reasonable amount of time on QA while still maximizing time spent on patient care activities.

Indicators, criteria, and threshold levels were developed in conjunction with the optometry staff to best reflect the types of optometric services provided by MAMC. Two indicators were selected for monitoring each month. The staff decided to start with two well-defined indicators to give the technicians collecting the data a chance to adapt to the new program. When technicians were not sure if all criteria had been met for any indicator, the medical record was set aside for review by an optometrist.

Peer review of medical records was also designed to have minimal impact on the optometrist's time. Each optometrist was expected to review approximately twenty-five patient records of another doctor's by the end of the month. Records were randomly selected throughout the month so that optometrists could utilize any available time between patients for record review. By conducting record audits between patients, one large block of time did not have to be scheduled at the end of the month for review of twenty to thirty medical records.

Patient satisfaction surveys were administered to patients to determine if the surveys were easy for patients to complete or if any of the questions were confusing or difficult to answer. Surveys were administered to one or two patients per doctor per day. The MAMC optometric staff (with the exception of the receptionist) was not aware which patients were selected to complete surveys until after the end of the examination. Following the examination, the clinic receptionist would randomly select those patients identified for survey completion. By not designating patients intended to complete surveys prior to their examination, survey results were as unbiased as possible.

Results

Monitoring and Evaluation Process

Four indicators were monitored over the sixty day test period by the MAMC Optometry Service. Two indicators were selected for monitoring and evaluation during the month of May and two different indicators for June. The two optometry clinics that comprise the Optometry Service monitored the same indicators each month. Data collection was performed by optometric technicians at both optometry clinics; thereby, allowing optometrists additional patient time. Since optometric technicians had been thoroughly briefed on the data collection required for each indicator being monitored, no difficulties were

encountered in data collection. Easily measurable and objective indicators and criteria were selected for the test period to avoid confusion on the part of the technicians during data collection as to whether the criteria for any indicator were satisfied or not.

For the month of May, indicators number five (high myopia) and number eight (large cup-to-disc ratio with borderline intraocular pressures) were monitored and evaluated (Appendix A, pages C-8 and C-11). Indicator number five (high myopia) had five patients identified for the month as meeting the indicator, with all five patients meeting the corresponding criteria. The threshold for this indicator had been set at 90%, with the actual compliance rate determined to be 100%. Based upon a very small sample size, the quality of care established by the Optometry Service for this indicator was being met. No occurrences for indicator number eight (large cup-to-disc ratio with borderline intraocular pressures) were identified by the Optometry Service for the month of May.

For the month of June, indicators number one (patient satisfaction) and number two (macular changes) were monitored (Appendix A, pages C-4 and C-5). As with indicator number eight monitored during the month of May, indicator number two had no occurrences for the month of June. Indicator number one successfully met its threshold level with a patient satisfaction rate measured at 100%. This was well above the pre-established threshold level of 85%. Additional results obtained from the patient satisfaction surveys is found on page seventeen.

Peer Review of Medical Records

Peer review was conducted during the test period on seventy-eight patient medical records. This was an average of approximately twenty records per optometrist per month. Peer review consisted of record audits for both

administrative and clinical deficiencies and was recorded on the Peer Review Record Sheet (Appendix A, page E-1). Patient records were randomly selected for review and delivered to the appropriate optometrist by one optometric technician at each optometry clinic. Of the seventy-eight records reviewed, only one administrative deficiency was identified (provider name stamp missing). The administrative deficiency was brought to the attention of the responsible provider by the reviewing optometrist and immediately corrected.

No difficulties were identified with the Peer Review Record Sheet. Providers interviewed after the test period felt that the Peer Review Record Sheet was easy to use and helped simplify the review process.

Measuring Patient Satisfaction

Patient satisfaction surveys were completed by seventy patients during the test period. Patients were very cooperative in completing the surveys and reported that the surveys were easy to understand and complete. Average completion time for the majority of patients was five to eight minutes. Both optometry clinics randomly surveyed their respective patient populations. Although the patient populations of the two clinics that comprise the MAMC Optometry Service were diverse, the results obtained were similar. The optometry clinic at the troop medical clinic surveyed thirty-eight patients, with 88% of the patients active duty soldiers, 3% retired service members and their family members, and 8% civil service personnel. The optometry clinic at the hospital surveyed thirty-two patients. The thirty-two patients consisted of 10% active duty soldiers, 63% family members of active duty soldiers, and 27% retired service members and their family members.

Both optometry clinics had 100% patient satisfaction with the services provided, as defined by indicator number one (Appendix A, page C-4).

No difficulties were identified with any of the question formats utilized within the survey. The Likert scale questions helped identify those areas needing to be improved, while highlighting those areas with which patients were particularly pleased. Overall, patients felt the services provided by the Optometry Service were very professional. Areas most frequently identified for improvement were: the condition of the waiting area, lack of reading material in the waiting area, and lack of entertainment in the waiting area (i.e. no television or radio).

CHAPTER 4. DISCUSSION AND SUMMARY

Discussion

The goal of this project was to develop a comprehensive QA program for Army optometry. The program had to be based upon current JCAHO and Army regulatory requirements and be adaptable to most Army optometry clinics. It also had to be practical in nature and require minimum time for it to be widely accepted by Army optometrists.

The results of the MAMC test period indicate that the QA program developed is a practical program that is adaptable to real clinical situations. The three components used to build the Army Optometry QA program (the monitoring and evaluation process, the peer review of medical records, and the measurement of patient satisfaction) were successful at their intended tasks.

Measurement of patient satisfaction was done in a practical and timesaving manner so that useable data was obtained easily. The MAMC optometric staff was extremely pleased with the information gathered from the patient satisfaction surveys. Several areas highlighted in the completed surveys have already been identified by the optometric staff for future improvement.

The peer review of medical records was successful at reviewing the quality of care being provided by the Optometry Service. The peer review process allowed every provider, even optometric student externs, to have their work randomly reviewed. The MAMC optometric staff anecdotally reported after the test period that just knowing patient records were randomly being audited improved the quality of the work being done. The optometrists also reported that medical record entries were more thorough and legible since the peer review process had been initiated.

The monitoring and evaluation process had some difficulties becoming operational. During the test period, it became apparent that several indicators and criteria developed by the MAMC optometric staff were not suitable for the current mission the Optometry Service was fulfilling. Currently, the Optometry Service has a patient population comprised primarily of active duty soldiers and their family members. This patient population is a relatively healthy one, with minimal ocular pathology. Because of this high percentage of young, healthy patients, indicators such as indicator number eight (large cup-to-disc ratio with borderline intraocular pressures) and indicator number two (macular changes) should have been eliminated due to the anticipated small sample size. Development of indicators and criteria that accurately reflect the mission of the optometry clinic is critical for the monitoring and evaluation process to be effective.

The QA program required a time commitment of approximately two hours per month for each of the staff optometrists. This included the monthly Optometry Service Quality Assurance Committee (QAC) meeting and the monthly peer review of medical records. The optometrist serving as the Quality Assurance Monitor spent about four hours per month on QA activities. This included the monthly QAC meeting, the peer review of medical records, the evaluation of data collected by the optometric technicians, and the preparation of the QAC meeting minutes. Each of the optometry clinics had one optometric technician spending approximately four to five hours per month on the QA program. None of the optometrists or optometric technicians felt the time required for the QA program was excessive.

Summary

The purpose of this project was to develop a comprehensive QA program for Army optometry. That program was developed and tested at a major Army medical center without any significant problems being identified. The QA program developed is realistic, practical, and requires a minimal time commitment from the optometric staff. Army optometrists now have at their disposal a means of updating themselves on QA terminology and techniques. Any optometrist could easily use this manual to build a comprehensive QA program meeting both the requirements of the JCAHO and the Army.

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APPENDIX A. ARMY QUALITY ASSURANCE MANUAL

ARMY OPTOMETRY

QUALITY ASSURANCE MANUAL

MARCH 1991

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Preface

The sample quality assurance program included in this manual was written for the Optometry Service at Madigan Army Medical Center (MAMC). With minor revisions, it can serve as the quality assurance program for the Optometry Service at any Army medical treatment facility (MTF).

This quality assurance manual was completed by MAJ Rob Drescher in partial fulfillment of the degree requirements for the Master of Science degree in Clinical Optometric Management at Pacific University. Advising MAJ Drescher were Doctors John R. Roggenkamp, A.R. "Dick" Reinke, James E. Peterson, and William E. Preston.

Portions of the quality assurance program presented in this manual were obtained from the Optometry Service Standing Operating Procedures (SOP) of Tripler Army Medical Center and Brooke Army Medical Center. Special thanks to the optometrists at those facilities for contributing material. Also extremely helpful as reference sources were the MAMC Quality Assurance Coordinator, Mrs. Mary Honn; MAMC Regulation 40-20, Quality Assurance Program; MAJ Ann Brazil, Army Nurse Corps; and MAJ James Chapman, U.S. Air Force.

Corrections, suggestions, or comments on the The Army Quality Assurance Manual should be directed to MAJ Robin Drescher on the Army Optometry Network (AOPTNET). Copies of the manual are also available on AOPTNET.

The views expressed in this manual are the author's, and do not necessarily reflect the position of the Department of the Army or the Army Medical Department. These views should not be considered doctrine nor a replacement of existing regulations or guidelines.

Quick Reference Sheet

Introduction

1. What exactly is quality assurance (QA)? QA is an administrative device that is used to monitor performance. The term QA in no way implies a standard of perfection or the complete elimination of human error. QA attempts to identify and resolve problems found in either the quality or the appropriateness of care, and to increase the effectiveness of health care within available resources.

2. An effective quality assurance program (QAP) for either civilian or military MTFs is primarily based upon guidance supplied by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Army Regulation (AR) 40-68, Quality Assurance, serves as an additional reference source for Army QAPs. Health Services Command (HSC) provides additional guidance to Army MTFs located within the United States. Together, the JCAHO, AR 40-68, and HSC provide the guidance necessary for Army health care personnel to operate comprehensive and effective QAPs.

3. This quality assurance manual is intended to familiarize Army optometrists with the components of a comprehensive QAP. Some Army optometrists are already knowledgeable on QA. Those optometrists may find this manual helpful for updating individual sections or specific components of their own quality assurance programs. For those optometrists less familiar with QA, this manual provides a starting point towards building a successful program.

4. Central to any QAP is the JCAHOs ten-step monitoring and evaluation process. This process is highlighted beginning on page 9 of this manual. The primary advantage of using the monitoring and evaluation process is that QA resources are focussed upon important aspects of care. The monitoring and evaluation process can also be used in identifying trends or patterns of care which may not be apparent when only case-by-case review is used.

5. The sample indicators, criteria, and threshold levels are provided as examples only. **THEY DO NOT REPRESENT ANY ATTEMPT TO ESTABLISH MINIMUM STANDARDS OF CARE FOR THE OPTOMETRIC PROFESSION OR FOR ARMY OPTOMETRY.** Each clinical situation will require indicators, criteria, and threshold levels to be adapted to a specific clinic's location and operational mode. Before initiating a clinic QAP, all optometrists assigned or attached to the clinic should meet and discuss appropriate values for indicators,

clinical criteria, and threshold values. The more input the clinic staff has in quantifying the monitoring and evaluation process, the higher the acceptance will be for the overall QAP.

6. Collection of data during the monitoring and evaluation process should be continuous. Daily data collection allows a few records to be reviewed every day, rather than numerous records at one monthly meeting. This spreads the time required for QA activities over a greater period and minimizes its impact on patient care activities. Daily data collection also allows negative trends or patterns of care to be identified in a much more timely manner, so corrective action can be taken sooner.

7. The peer review of medical records should be conducted on a daily basis rather than once a month. As with data collection in the monitoring and evaluation process, the time required reviewing a few randomly selected records every day has a minimal impact when compared to reviewing 20 to 30 medical records at one sitting. Also, daily record audits can identify cases of substandard or inappropriate care much sooner so deficiencies can be more quickly corrected.

8. The sample patient satisfaction survey included within the QAP is an example of the type of survey which can be used to measure the satisfaction level of patients being seen in the clinic. Every clinic situation is different. Every clinic's satisfaction survey will have slightly different requirements. The common denominator for all clinics is that the measurement of patient satisfaction will be present in every QAP. Patient satisfaction has become a valid outcome indicator and will be assessed in measuring the quality of care.

MADIGAN ARMY MEDICAL CENTER
OPTOMETRY SERVICE
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HSHJ-CM-O 24 January 1991

QUALITY ASSURANCE PROGRAM

MADIGAN ARMY MEDICAL CENTER
OPTOMETRY SERVICE
QUALITY ASSURANCE PROGRAM

HSHJ-CM-O 24 January 1991

1. PURPOSE. The purpose of this Quality Assurance Program (QAP) is to ensure the provision of the highest quality patient care by the Optometry Service with its available resources. The QAP is designed to systematically and objectively monitor and evaluate the availability, quality, and appropriateness of patient care. Additionally, the QAP will identify opportunities to improve care, resolve problems in the delivery of care, and resolve problems in the performance of individual health care providers.

2. OBJECTIVE. The objectives of the QAP are to:

a. Deliver quality patient care subject to the availability of space and facilities and the capabilities of the optometric staff.

b. Reduce risk-creating incidents and adverse effects to patients.

c. Improve provider-patient communication and patient satisfaction.

d. Enhance coordination and communication among optometrists and support staff.

e. Objectively evaluate practitioner performance through performance-based criteria and other quality assurance methods.

f. Maintain optometric skills and knowledge at satisfactory levels.

3. SCOPE. The Chief, Optometry Service evaluates the quality and appropriateness of patient care, utilization of resources, risk management, and optometrist credentialling and privileging. The Chief, Optometry Service will appoint one of the assigned optometrists to serve as the Quality Assurance Monitor to coordinate all quality assurance, risk management, and utilization management activities. All military and civilian optometrists and eye specialist technicians assigned to or working in the Optometry Service will actively participate in the QAP. All other staff members working in the service will assist in providing quality care and will adhere to all standards set by the QAP. The scope of optometric care provided by the Optometry Service is listed in Appendix A.

4. RESPONSIBILITIES.

a. The Commander, Madigan Army Medical Center (MAMC) represents the governing body (Health Services Command) at the local level and therefore has overall responsibility for providing quality care to all beneficiaries of medical services at MAMC. The Deputy Commander for Clinical Services (DCCS) serves as the director of the MAMC QAP.

b. The Chief, Department of Community Medicine is accountable to the DCCS for all professional and administrative functions within the department, including quality assurance activities. As part of the Department of Community Medicine, the Chief, Optometry Service is responsible for the implementation and conduct of an effective QAP for the Optometry Service.

c. The Chief, Optometry Service will be responsible for:

(1) Ensuring that the quality and appropriateness of optometric patient care is monitored and evaluated systematically on an ongoing basis.

(2) Appointing one optometrist to serve as the Quality Assurance Monitor who is responsible for the Utilization Management Program, Risk Management Program, and the QAP for the Optometry Service.

(3) Establishing an Optometric Quality Assurance Committee (QAC) with the responsibilities of coordinating, integrating, and directing the QAP. The Chief, Optometry Service will serve as the Chairperson of this committee. All military or civilian optometrists assigned to or working in the Optometry Service are members of the QAC. The Optometry Service Noncommissioned Officer-in-Charge (NCOIC) will also be appointed a member. Additional personnel may be added to the QAC at the discretion of the Chairperson.

(4) Developing criteria for recommending clinical privileging based upon the optometrist's credentials and performance.

d. The Quality Assurance Monitor will be responsible for:

(1) Developing the list of indicators, criteria, and threshold levels that will be monitored and evaluated by the Optometry Service for the next calendar year. Guidance will be provided by the QAC in selecting the specific indicators, criteria, and threshold levels. Final approval of all items

selected for monitoring and evaluation is required by the QAC Chairperson. Appendix B contains the annual schedule.

(2) Ensuring all data needed for monitoring the care provided by the Optometry Service is collected in a timely manner. Evaluation of the collected data will be conducted monthly to determine if threshold levels have been reached. Results of the monitoring and evaluation of care will be discussed by the QAC during the monthly meeting and documented in the QAC minutes.

(3) Preparing QAC meeting agendas, minutes, and all reports submitted to the Department of Community Medicine.

(4) Keeping a record of all open quality assurance items until items are resolved or closed.

(5) Maintaining a quality assurance notebook of all important quality assurance documents, to include, the yearly list of indicators for monitoring and evaluation, the monthly data collected during monitoring and evaluation, minutes of past QAC meetings, local regulations concerning quality assurance, etc.

(6) Ensuring the availability of the required number of medical records for monthly peer review. The Quality Assurance Monitor will tabulate the results of the monthly record review for inclusion in that month's QAC minutes.

(7) Educating all Optometry Service personnel on quality assurance and the QAP. New personnel will be briefed on the QAP within 30 days of assignment to the Optometry Service. All other personnel not assigned to the QAC will receive QA briefings as needed to remain current on QA issues.

e. The Optometric Quality Assurance Committee Members will be responsible for:

(1) Participating in the monitoring and evaluation of patient care provided by the Optometry Service as directed by the Chief, Optometry Service and the Quality Assurance Monitor.

(2) Attending monthly QAC meetings unless excused by the Chief, Optometry Service.

(3) Assisting in the data collection required for monitoring patient care, as directed by the Quality Assurance Monitor.

(4) Conducting medical record peer reviews on a monthly basis.

(5) Being familiar with the purpose, objectives, and operation of the Optometry Service's QAP.

5. ORGANIZATION/STRUCTURE.

a. The QAC is responsible for meeting at 1300 hours on the last Friday of each month. The Chairperson has the authority to change the time and date of the meeting and will notify the QAC members as needed. Items to be discussed at each QAC meeting will be determined by the Quality Assurance Monitor and the QAC Chairperson. A pre-published agenda for each meeting will be distributed to the QAC members at least 3 days prior to the meeting date. A working quorum for all QAC meetings will be 50% of the assigned membership.

b. The Joint Commission on Accreditation of Healthcare Organization's (JCAHOs) ten-step monitoring and evaluation process will be used by the Optometry Service to effectively utilize its available resources and to manage the quality of care provided. Monitoring and evaluation activities involve the examination of care provided, identification of deficiencies in that care, and improvement, as necessary, of the quality of care. Monitoring is ongoing, criteria-based, planned, and systematic. Items selected for monitoring will include high volume, high risk, high cost, and problem prone patient activities. The essential steps in monitoring and evaluation include the following:

(1) Assign Responsibility. The Chief, Optometry Service is responsible for the service's monitoring and evaluation activities. The Chief will assign quality assurance responsibilities to others within the service.

(2) Delineate Scope of Care. The diagnostic and therapeutic modalities utilized by the Optometry Service are identified, as well as the types of patients served. (See Appendix A).

(3) Identify Important Aspects of Care. After the scope of care is defined, the QAC selects those activities that are the most important to monitor for the quality and appropriateness of care. Highest priority is usually directed toward high volume, high risk, high cost, or problem prone aspects of care.

(4) Identify Indicators. An indicator is a well-defined, objective variable used to monitor the quality and appropriateness of an important aspect of care. It can be a resource, clinical event, complication, or outcome of treatment provided. The QAC will determine the indicators and criteria to be monitored annually. Appendix C contains the indicators used within this QAP.

(5) Establish Thresholds for Evaluation. A threshold is an acceptable or expected level of deviation. When a threshold is exceeded, a more in-depth evaluation of the activity is conducted so as to determine the cause of deviation. Thresholds will be determined by the QAC based upon authoritative sources and supported by the best available clinical and quality assurance literature.

(6) Collect and Organize Data. Data collection will be ongoing. Data will be compared with pre-established criteria and analyzed to detect potential problems, trends, and patterns of performance.

(a) Data sources will include, but not be limited to, the medical record, incident reports, surveys and questionnaires (patient satisfaction or complaints), external peer review reports, etc. The Quality Assurance Monitor is responsible for ensuring all necessary data is collected for the indicators being monitored and compared to the pre-established threshold levels. The Quality Assurance Monitor may collect the data or designate another member of the Optometry Service as a data collector. Data should be collected on a daily basis, rather than at the end of the month, to allow deficiencies in care to be identified in a timely manner. Data will be collected using the Data Collection Grid (Appendix D).

(b) DATA WILL BE COLLECTED ON COMPLETED EXAMINATIONS ONLY. For example, if according to the criteria, a patient is required to have a dilated fundus examination but must be rescheduled for completion of the dilated exam, the patient's initial visit is not used for data collection purposes. When the patient returns for the dilated exam and all testing is completed, the record may become part of the data collection process and both exams will be reviewed to ensure that all criteria have been met.

(c) For the purposes of monitoring and evaluating the quality of care provided by the MAMC Optometry Service, approximately 50% of the medical records of patients examined in the service will be reviewed. (The percentage of records reviewed during monitoring and evaluation will vary depending

upon the indicator selected and the individual clinic itself. For example, if the indicator involving diabetic patients is selected and the clinic sees only ten diabetic patients in one month, 100% of the records should be reviewed. If 90 diabetic patients are seen in one month, about 30% of the records should be reviewed. Once the QAP is operational, the number of records reviewed can be adjusted up or down so that a reasonable sample size can be obtained. Twenty to thirty records reviewed per indicator per month is a reasonable sample size).[1]

(7) Evaluate Care When Thresholds Are Reached. When a threshold for evaluation is not achieved, that aspect of care being monitored is reviewed to identify problems or opportunities for improvement. The review will be conducted by the QAC under the direction of the QAC Chairperson.

(8) Take Actions to Improve Care. The evaluation may conclude that the care is acceptable and that no further action is necessary. When the evaluation identifies an area of concern, a plan is formulated and implemented to solve or reduce the problem, and/or to improve care. This plan must identify who or what is expected to change, who is responsible for implementing the corrective action, what corrective action is appropriate, and when change is expected to be implemented. If the needed corrective action exceeds the Optometry Service's authority, recommendations are forwarded to the individual or committee that has the authority to act. Appropriate actions may consist of:

(a) Adding or developing classes, training activities, providing referenced sources, or by restructuring existing educational procedures.

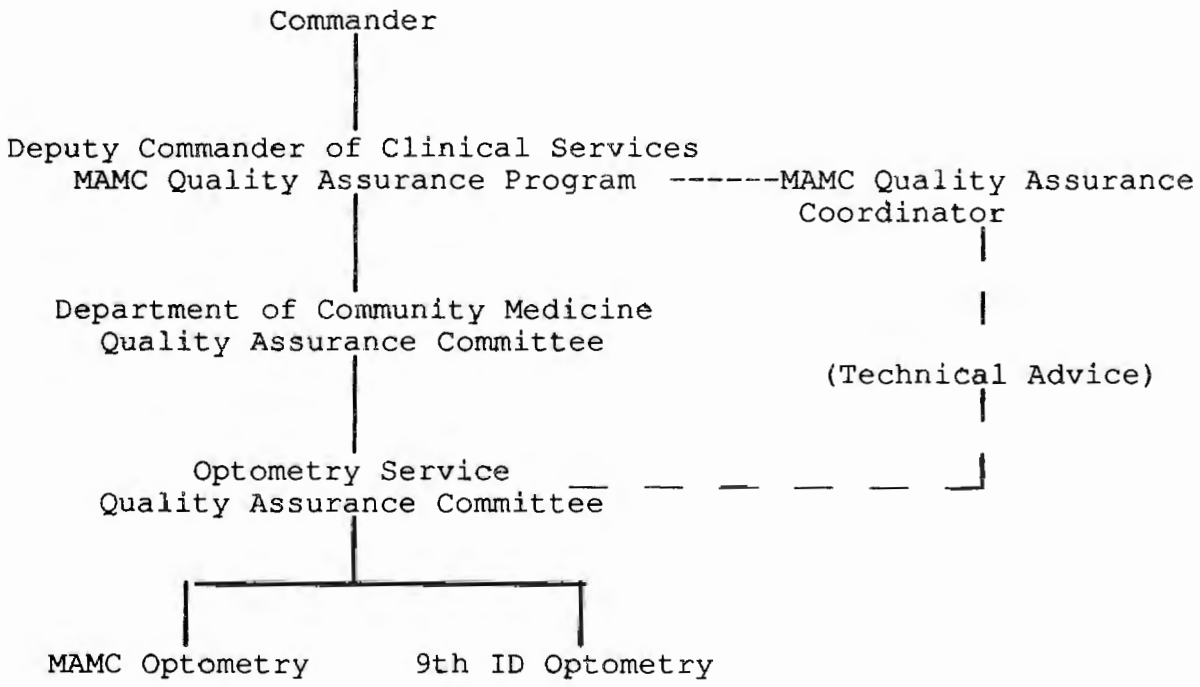
(b) Changing policies and/or procedures, redistributing staff, altering use of equipment or supplies, and/or improving communications.

(c) Counselling personnel, increasing supervision, changing duties, transferring or withdrawing certain privileges of involved individuals.

(9) Assess the Effectiveness of the Actions and Document Improvement. After allowing enough time for change to occur, a follow-up assessment is conducted to determine if the corrective action has resulted in solution of the problem and improvement in patient care and services. Continued monitoring will be accomplished to document the improvement in patient care for a minimum of one month.

(10) Communicate Relevant Information to the Organizationwide Quality Assurance Program. Monitoring and evaluation information will be communicated to the QAC and included within the monthly minutes. QAC minutes will be in the format required in MAMC Regulation 40-20 (Appendix G) and submitted to the Department of Community Medicine on a monthly basis.

c. The flow of quality assurance information into and out of the Optometry Service is shown below.



6. COMPONENTS. Integration of the four QAP components (patient care evaluation, credentials review and privileging, utilization management to include access to patient care, and risk management) assures a comprehensive, broad-spectrum approach to identifying both problems and opportunities to improve care.

a. Patient Care Evaluation. The review of medical records and other appropriate documents or sources of information is conducted in order to evaluate the quality of optometric care provided to patients. Included within patient care evaluation are the following activities:

(1) Peer review. Peer review is a process of ongoing retrospective evaluation of care as documented in outpatient medical records. This peer review is conducted monthly and is a separate process from the peer review triggered when threshold levels are not reached during monitoring and evaluation. HSC recommends a minimum of 10% or 25 medical records be audited during the monthly peer review.[2] Records for monthly peer review will be selected randomly and reviewed for both administrative and clinical deficiencies. Administrative review will ensure that appropriate documentation is achieved. Clinical review will ensure that a minimum optometric exam is performed and documented, that a SOAP (subjective, objective, assessment, plan) format is followed, and in the reviewer's opinion, appropriate optometric care has been provided. The results of each medical record review will be noted on the Peer Review Record Sheet (Appendix E) and maintained in the quality assurance notebook. A monthly summary of all cases reviewed will be completed and incorporated within the QAC minutes.

(a) Administrative deficiencies. Deficiencies of an administrative nature will be corrected, when possible, by the reviewer. All administrative deficiencies will immediately be brought to the attention of the care provider to facilitate improved performance and will be discussed at the next monthly QAC meeting.

(b) Minor optometric clinical deficiencies. Any action or inaction by the optometrist considered by his/her peers to represent the provision of less than optimal care, but which does not pose a potential risk of damage/loss of eyesight or health is considered minor. Such a deficiency could potentially result in temporary blurred or double vision, inefficient binocular vision, reading difficulties, asthenopia, etc. The majority of optometric tests and procedures, if not done, done improperly, or not adequately documented, would represent minor clinical deficiencies.

(c) Significant optometric clinical deficiencies. Any action or inaction of the optometrist considered by his/her peers to represent sub-standard care, which poses a potential risk of damage/loss of eyesight or health, is considered a significant deficiency. The tests and procedures used to evaluate external and internal ocular health (e.g., tonometry, biomicroscopy, pupillary responses, and ophthalmoscopy) if not done, done improperly, or not adequately documented, would represent significant clinical deficiencies.

(d) All clinical deficiencies will immediately be brought to the attention of the responsible care provider by the Quality Assurance Monitor. If it is minor and the provider agrees with the cited deficiency, then it is that provider's responsibility to take the necessary action to resolve the deficiency. If disagreement exists over the minor deficiency, the case will be discussed at the QAC meeting. A majority decision will determine if a deficiency occurred, the action(s), if any, required to resolve the situation, and ways to improve future care. All significant clinical deficiencies will be brought to the immediate attention of the Chief, Optometry Service. The Chief, Optometry Service will investigate all such occurrences to determine validity, ensure that timely appropriate care is obtained and counsel the care provider to reduce the chance of reoccurrence. Those deficiencies determined to have real or potential serious adverse effects on the patient or to MAMC, will immediately be reported to the Chief, Department of Community Medicine by the Chief, Optometry Service.

(e) All deficiencies, both administrative and clinical, will be discussed at the next QAC meeting and entered into the QAC minutes.

(f) Analysis of the deficiencies will be conducted to determine where and how improvements in care can be achieved. Any patterns or trends detected for an individual or group of optometrists will be discussed at the next QAC meeting and entered into the QAC minutes. The QAC will plan and implement actions to improve care and follow-up will be done at subsequent meetings to ensure resolution of the problem.

(2) Indicators. Indicators of care will be developed which are pertinent to the practice of optometry at MAMC. Use of indicators will be an ongoing process. A minimum of two important aspects of care will be monitored monthly, each with a minimum of one indicator.[3] Each indicator will generally be kept in place for a minimum of one month. The process will closely follow the ten-step monitoring and evaluation model used by the JCAHO. Whenever a threshold level is not reached for any indicator, that indicator will continue to be monitored on a monthly basis until the problem has been resolved.

(3) Supervision of Fourth Year Optometry Students. Students and staff will be thoroughly familiar with the Optometry Student Externship Program, MAMC Optometry Service SOP. Preceptors are responsible for the optometric care provided by students. Close monitoring of students is mandatory to ensure the provision of appropriate care. The emphasis of

the student externship program will be to provide a learning experience for students while continuing to provide high quality care. Students are not licensed or privileged to practice independently and as such must be supervised by a licensed optometrist who is ultimately responsible and accountable for the care of the patient.

(4) Product quality assurance. Product quality assurance will consist of verification of spectacle prescriptions to ensure compliance with the current standards for ophthalmic lenses recommended by the American National Standards Institute (ANSI). Spectacles fabricated by military labs, safety spectacles fabricated by civilian labs, and spectacles procured by Army and Air Force Exchange Service (AAFES) customers will be inspected. AAFES is required to present spectacles to the Optometry Service for inspection on a regular basis. There will be 100% verification of safety spectacles and contact lenses prior to dispensing to the patient. All spectacles fabricated by the military labs will be verified each month. Military labs will be notified if less than 98% of the spectacles do not meet current ANSI standards. Results of the product quality assurance inspections will be presented at the QAC meeting.

(5) Patient Satisfaction Surveys. Patient satisfaction is recognized as an integral component of quality assurance programs. It is one of the few methods available of measuring the inter-personal relationship between optometrist and patient. As recommended by HSC Pamphlet 40-7-23, Ambulatory Patient Care - Patient Representative Officer, patient satisfaction must be measured at least annually and at least 85% of the responses should be favorable.[4]

(a) The MAMC Optometry Service will designate patient satisfaction as an indicator for monitoring and evaluation at least three times annually. By surveying three times per year, a more realistic picture can be obtained on the patient's perception of the quality of care they have received. Appendix F contains a copy of the MAMC Optometry Service's patient satisfaction survey and the formulas from HSC Pamphlet 40-7-23 that are needed to determine the number of surveys required for completion.

(b) Patients will be randomly selected by the Quality Assurance Monitor for satisfaction survey completion without the examining doctor's knowledge. As the patient leaves the doctor's examination room, those patients identified to complete surveys will be directed to a private area in the

clinic and allowed to complete the survey. Once the survey is finished, it will be placed by the patient in a "ballot-box" type container to guarantee patient confidentiality. At the end of the month, the surveys will be tallied and the results analyzed.

b. Credentials Review and Privileging. Credentials review and privileging must be effective in order to maintain quality health care.

(1) Credentials review includes verification of current licensure, certification, education, training, experience, and current competence. These activities are completed by the MAMC Credentials Coordinator when initiating or completing a Practitioner Credentials File (PCF). (See Appendix H for definition of a PCF). Practitioners assigned to MAMC from another MTF will have the credentials coordinator of the losing MTF forward the PCF by certified mail, return receipt requested, to the Commander, MAMC.

(2) Privileging provides for processing through MAMC Credentials Committee channels those practitioners given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical care. This includes optometrists. The privileging process is directed solely and specifically toward the provision of quality patient care and is not a disciplinary or personnel management mechanism. Recommendations for the granting of clinical privileges will be made by the Chief, Optometry Service, acted upon by the MAMC Credentials Committee, and forwarded to the Commander, MAMC for approval or disapproval.

(3) Provisional privileges are given to practitioners newly assigned to a facility or discipline; for example, when practitioners first come on active duty or become employed by the Army Medical Department, or change duty stations. The period for provisional privileges will be 365 days; however, the provisional privileges may be reviewed at any time by the Commander and defined clinical privileges granted based on the review.

(4) Granting of defined clinical privileges will be based on education, specific training, experience, current competence, and completion of a satisfactory provisional period. Reappraisal of defined clinical privileges will be completed at least every 2 years. DA Form 5440-6-R, Delineation of Privileges - Optometry Service (contained in the back of AR 40-68), will be completed by the optometrist requesting clinical privileges and approved by the Chief, Optometry Service before

forwarding to the credentials committee. The Chief, Optometry Service will use the following guidelines in approving or disapproving DA Form 5440-6-R requests for optometric clinical privileges:

(a) Requests for Category I privileges will be approved for any optometrist who is a graduate of an accredited school of optometry acceptable to The Surgeon General, possesses a current license to practice optometry in the United States, U.S. Territories, or the District of Columbia, and is a graduate of the AMEDD Officer Basic Course. Privileges may be granted to optometrists who have satisfactorily completed formal optometry training but have not been licensed to practice optometry. Optometrists without licenses will require direct supervision until licensed.

(b) Requests for Category II and Category III privileges will be approved for any optometrist who meets the requirements for Category I privileges and who demonstrates the knowledge and clinical skills required for either Category II or Category III. The Chief, Optometry Service may approve Category II or Category III privileges based upon successful completion of a 100 hour Concentrated Ocular Therapeutic Course, successful completion of the Examination in Treatment and Management of Ocular Disease offered by the International Association of Boards of Examiners in Optometry (IAB exam) or its nationally recognized equivalent, or past training and experience.

(c) Requests for clinical profiling privileges (which must be designated by the MTF Commander in accordance with AR 40-501, Chapter 7) can be included in the "Additions" section of DA Form 5440-6-R.

(5) Renewal of privileges in all categories will be based upon education, training, experience, appraisals of clinical performance, Provider Activity File (PAF) data, professional conduct, and health status. (See Appendix H for definition of PAF).

(6) Evaluation of clinical and interpersonal skills will be completed annually on DA Form 5374-R, Performance Assessment, by the Chief, Optometry Service. It will include documentation of the results of peer review especially with regard to superior or substandard performance.

c. Utilization Management. Utilization management (UM) seeks to assure appropriate allocation of the Optometry Service's resources by striving to provide quality patient care in the most cost-effective manner.

(1) The Chief, Optometry Service will designate one optometrist to be responsible for the UM program for the Optometry Service.

(2) The following will be evaluated by the Optometry Service under UM:

(a) Review of the adequacy, distribution and availability, and use of resources for patient care and services, including space, personnel, supplies, and equipment.

(b) Use of supplemental care.

(c) Impact of administrative actions such as leaves and passes, scheduling, etc.

(d) Review and assessment of resource utilization statistics on accessibility of care, personnel and staffing, and volume of care delivered to patients. Patient appointment data and provider-specific productivity data will be analyzed.

(e) Quarterly review of the priorities assigned to the Optometry Service's equipment on any high-cost procurement list (items whose unit cost exceeds $15,000).

(f) Annual assessment of high-cost equipment belonging to the Optometry Service.

(3) UM will be discussed during the monthly QAC meeting and documented in the QAC minutes.

d. Risk Management. Risk management (RM) is concerned with accident and injury prevention and minimizing the cost of claims and other financial losses. It encompasses not only the reduction of financial loss to the government but the reduction of risk to patients presented for diagnosis and treatment, and to visitors, family, and Optometry Service personnel.

(1) The Chief, Optometry Service will designate one optometrist to be responsible for the RM program for the Optometry Service.

(2) All serious adverse events, whether or not they are compensable, will be promptly investigated by the Optometry Service Risk Manager. An adverse event occurs when a patient suffers any unintended or unexpected negative result during patient care. Immediate action will be taken to ensure that the patient is protected from additional injury and to mitigate the

untoward effects of the event. The patient will be informed by the primary provider of the effects of the event on his or her health and the prognosis.

(3) When an adverse event occurs, the Optometry Service Risk Manager will ensure that DA Form 4106 (Quality Assurance/Risk Management Document) is prepared and submitted to the Chief, Optometry Service within 24 hours of the occurrence. If life-threatening injury or death has occurred, the Commander, MAMC will also be notified. The Chief, Optometry Service will forward DA Form 4106 through the Department of Community Medicine to the MAMC Risk Manager as soon as possible but in all cases within 48 hours of the occurrence.

(4) All MAMC infection control policies and safety programs will be followed by the Optometry Service to minimize risk for both patients and staff.

(5) RM items will be discussed during the monthly QAC meeting and entered into the QAC minutes

7. REPORTING.

a. QAC meeting minutes constitute the basis for the formulation of a viable QAP. QAC minutes will be prepared in accordance with MAMC Regulation 40-20 and use the CRAEF (conclusions, recommendations, action taken, evaluation, follow-up) format. QAC minutes will document findings in all components of the QAP. Appendix G contains an example of the required format for QAC minutes.

b. QAC minutes are submitted within 5 working days of the meeting date to the Chief, Department of Community Medicine for approval. An information copy of the approved minutes will be provided to each QAC member.

c. QAC minutes will not refer to any case in a way that will allow a patient or any of the personnel attending him/her to be identified (for example, social security number, patient's register number, or practitioner's name). The Quality Assurance Monitor will assign a reference number to all cases for tracking purposes prior to their being discussed by the QAC. Confidentiality will be maintained in accordance with the provisions of AR 40-66, Chapter 2.

d. Public Law 99-660 provides that records created by or for the Department of Defense in a medical QAP are confidential and the property of the U.S. Government and precludes disclosure

of or testimony about any records or findings, recommendations, evaluations, opinions, or actions taken by the QAC.

8. EVALUATION. The Optometry Service will review in November the objectives, scope, organization, and overall effectiveness of the QAP. This appraisal will be documented as part of the QAC minutes. Appropriate revisions to the QAP will be made based upon the recommendations of the MAMC Quality Assurance Coordinator and any new guidance on quality assurance published by the JCAHO. The annual appraisal should include:

a. The effectiveness of the monitoring and evaluation process.

b. The QAP and the activities performed.

c. Whether the information collected was shared and communicated as appropriate.

d. Whether the information communicated resulted in improving patient care or resolving identified problems.

e. Recommendations for changes in the QAP.

9. REFERENCES.

a. JCAHO Accreditation Manual for Healthcare Organizations, 1991.

b. AR 40-68, Quality Assurance Administration.

c. AR 40-66, Medical Record and Quality Assurance Administration.

d. AR 40-501, Standards of Medical Fitness

e. HSC Bulletin on Quality Assurance, No. 6, Oct/Nov 1990.

f. HSC Pamphlet 40-7-23, Ambulatory Patient Care--Patient Representative Officer.

g. MAMC Reg 40-20, Quality Assurance Program.

Encls

ROBERT H. PINSON, OD
COL, MS
Chief, Optometry Service

APPROVED/DISAPPROVED

JOHN R. SMITH, MD
COL, MC
Chief, Dept of Community Medicine

Appendix A

Scope of Optometric Care Provided

1. Categories of Patients Served:

a. Active duty military.
b. Civil service/civilian employees working in eye hazardous areas requiring occupational vision exams and/or safety spectacles (i.e. laser workers, high frequency radio workers, drill press operators, etc).
c. Family members of active duty military.
d. Retired military and their family members when referred from ophthalmology or another MAMC department. The eligibility of additional retired military and their family members to receive vision services at MAMC will vary with optometric staffing levels.

2. Types of Services Provided:

a. The following services are provided by licensed optometrists:

(1) Vision examination to include testing of binocular functions and near-point evaluations, as well as manifest and cycloplegic refractions.
(2) Contact lens evaluations, including fitting, dispensing, and progress evaluations.
(3) Therapeutic treatment of minor eye infections.
(4) Ocular photography
(5) Low vision examinations.
(6) Dilated fundus examinations.
(7) Anterior and posterior segment evaluation.
(8) Gonioscopy.
(9) Tonometry, both applanation and non-contact.
(10) Visual field testing and interpretation.
(11) Completion of the vision portion of driver's license renewal forms.
(12) Occupational vision screenings for designated personnel (i.e. laser workers, high frequency radio workers, etc.).
(13) Completion of the vision portion of physical exams, including annual, flight, retirement, occupational, and service academy examinations.

Appendix A (continued)

b. The following services are provided by optometry student externs:

(1) All the services listed in paragraph a, except items number 11, 12, and 13.

(2) Ordering, adjusting, and dispensing spectacles.

c. The following services are provided by eye specialist technicians:

(1) Screening patients prior to examination.
(2) Ordering, adjusting, and dispensing spectacles.
(3) Completion of the visual portion of physical exams for annual and retirement examinations.
(4) Ocular photography.
(5) Visual field testing.
(6) Tonometry, non-contact.
(7) Contact lens dispensing.
(8) Spectacle and contact lens verification.

3. Categories and Numbers of Personnel Assigned:

a. Five military optometrists.
b. Three optometric technicians.

ANNUAL SCHEDULE --- MONITORING AND EVALUATION

OPTOMETRY SERVICE

YEAR: _____

FREQUENCY	ASPECT OF CARE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TRIANNUALLY	1. Patient satisfaction			X			X				X		
	2. Macular changes			X			X				X		
	3. Contact lens wearers		X					X		X			
	4. Diabetic patients		X					X		X			
	5. High myopia					X			X			X	
	6. Hypertensive patients				X				X			X	
SEMIANNUALLY	7. Glaucoma patients	X			X								
	8. Cup to disc ratio	X				X							
ANNUALLY	9. Basic life support												X
	10. Qualified for patient care												X

Appendix C

Indicators, Criteria & Thresholds

1. The indicators, criteria, and threshold levels provided in this Appendix are **FOR EXAMPLE PURPOSES ONLY.** Each Optometry Service will select indicators, criteria, and threshold levels that are appropriate for their specific location and mode of practice. The indicators provided in this Appendix may be used as written or modified as needed. **THE EXAMPLES PROVIDED DO NOT REPRESENT ANY ATTEMPT TO ESTABLISH MINIMUM STANDARDS OF CARE FOR THE OPTOMETRIC PROFESSION OR FOR ARMY OPTOMETRY.**

2. INDICATORS. Clinical indicators are selected from the important aspects of care determined in Step #3 of the JCAHOs ten-step monitoring and evaluation process. Highest priority in selecting indicators is usually given to aspects of care that are high volume, high risk, high cost, or problem prone. Indicators can fall into one of three basic categories: structure, process, or outcome.

a. **Structure indicators** involve areas such as organization of the department, numbers of trained personnel, instrumentation available, and licensing and privileging of providers. (i.e. Do all the optometrists have a current state license?; Is the clinic staff trained in Basic Life Support?; etc.).

b. **Process indicators** look at what evaluations were completed on the patient and the appropriateness of the care that was provided. Process indicators are concerned with those functions carried out by practitioners, including assessment, treatment planning, technical aspects of performing treatment, management of complications, as well as the indications for treatments and procedures. (i.e. Should the patient have been dilated?; Should a referral have been made?; Was the patient seen in a timely manner considering the symptoms that were present?; etc.).

c. **Outcome indicators** are concerned with the final result of the care provided, not the care process itself. Outcome indicators include complications, adverse reactions, and short-term results of specific procedures and treatments. (i.e. Did the care provided solve the patient's problem?; Did the conjunctivitis resolve?; Did the patient adapt to their new spectacles?; etc).

Appendix C (continued)

d. Trends in quality assurance have shown that the majority of indicators in use currently are process or outcome indicators. The indicators selected for use in this QAP are predominantly process indicators with some structure indicators.

3. CRITERIA. Criteria are the measurement tools employed in describing structure, process, and outcome indicators. Criteria are the norms that define what the profession considers to be acceptable appropriateness or quality of care. Criteria are often developed from standards of practice used by the profession and should be based upon authoritative sources and supported by the best available clinical and QA literature.

4. THRESHOLD LEVELS. A threshold for evaluation is the level or point at which intensive evaluation of care is initiated. The clinic staff must determine an appropriate threshold level for each indicator. Threshold levels may be based upon empirical evidence or on professional judgment based on experience. When first starting the QAP, threshold levels may need to be adjusted up or down to reach a realistic level.

a. A threshold may be set at any appropriate level between 100% and 0%. Thresholds set at 100%(or 0%) demonstrate the importance the clinic places on even one incident occurring in that area. Just one occurrence would initiate an intensive quality evaluation. Typically, thresholds are set somewhere less than 100%(or greater than 0%) so that critical resources are not mobilized in evaluating every single occurrence.

b. As a general rule, the more important the indicator and its criteria to maintaining the patient's health, the more restrictive the threshold level. For example, clinic personnel decided that corneal ulcers secondary to contact lens wear were such a threat to a patient's vision that no occurrence of contact lens related ulcers would be tolerated. The threshold was then set at 100%. All contact lens wearers were expected to remain ulcer free, and any occurrence of a corneal ulcer would require an in-depth review of the care that was provided. In contrast, clinic personnel decided that all high myopes should receive a dilated fundus examination, but that there may be an occasional exception when patients would not be dilated (i.e. patient refuses to be dilated, parent does not want their child dilated, etc.), and therefore, the threshold might be set at 90%. This would permit an occasional high myope that was not dilated from initiating an in-depth evaluation of the care provided.

Appendix C (continued)

c. During the monitoring and evaluation process, thresholds for evaluation should be applied to each indicator for the clinic as a whole and for each separate practitioner. For example, during data collection thirty records of diabetic patients were reviewed. Of those thirty records, twenty-seven met the established criteria and three did not. Dr Jones had examined twenty of the patients and had met the criteria on each patient. Dr Smith had examined ten of the thirty patients, but had met the criteria on only seven. The Quality Assurance Monitor would need to ensure that Dr Smith understood the QAP and was made aware of the deficiencies even though the overall threshold rate for the clinic was an acceptable 90% (27 out of 30 meeting the criteria).

1. PATIENT SATISFACTION

INDICATOR:	Patients will be satisfied (rating of excellent or good on the patient satisfaction survey) with the overall quality of the care provided by the clinic.
THRESHOLD:	85%
SAMPLE	
SIZE:	Approximately 5% of patient visits for the month
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

HSC Pamphlet 40-7-23, Ambulatory Patient Care - Patient Representative Officer, 13 Aug 86, p. A-2.

2. MACULAR CHANGES

INDICATOR:	Patients with evidence of age related macular changes will have the following additional items completed annually: a. Amsler grid. b. Dilated fundus examination. c. Stereoscopic examination of the macula. d. Patient instructed on weekly home monitoring techniques to detect early changes in macular integrity and on what steps to take should any changes be noticed. e. Patient instructed to return for ocular examination within one year or sooner if changes occur.
THRESHOLD:	90%
SAMPLE **SIZE:** **FREQUENCY:**	 50% of applicable patients Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Alexander LJ. Primary care of the posterior segment. East Norwalk, CN: Appleton & Lange, 1989:168-174.

3. CONTACT LENS WEARERS

INDICATOR:	Contact lens wearers (daily wear) will receive an eye exam annually to include, at a minimum, the following: a. Contact lens fit and over refraction. (If the patient was fit with contact lenses by a local civilian eyecare practitioner, the patient may be referred to that doctor for completion of these items.) b. Best corrected visual acuity with spectacles. c. Anterior segment evaluation using the biomicroscope. d. Posterior segment evaluation. e. Tonometry. f. Copy of the contact lens prescription furnished to the patient if the prescription can be determined from the medical records.
THRESHOLD:	90%
SAMPLE **SIZE:** **FREQUENCY:**	 50% of applicable patients Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Classe JG, Harris MG. Liability and extended wear contact lenses. J Am Optom Assoc 1987 Oct; 58(10):851.

4. DIABETIC PATIENTS

INDICATOR:	Diabetic patients will have the following completed at least annually: a. Anterior segment evaluation with tonometry. b. Dilated fundus examination. c. Stereoscopic examination of the macula. d. Fundus photographs of any changes in retinal appearance. e. Referral to the health care provider managing the patient's diabetes if the patient has not been examined within six months or if a sudden change in the patient's health status is detected. f. Referral to ophthalmology, at the optometrist's discretion, for completion of items 'a' through 'd' above.
THRESHOLD:	90%
SAMPLE **SIZE:**	50% of all diabetic and borderline diabetic patients
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Anonymous. Preferred practice pattern on diabetic retinopathy. American Academy of Ophthalmology Sep 1989:1-28.

Classe JG. Optometrist's duty to detect retinal detachment. In: Legal aspects of optometry. Boston: Butterworths, 1989:324-325.

Alexander LJ. Primary care of the posterior segment. East Norwalk, CN: Appleton & Lange, 1989:76-77,145.

5. HIGH MYOPIA

INDICATOR:	Patients with a refractive error greater than -7.00D in any meridian in either eye will have a dilated fundus examination completed annually.
THRESHOLD:	90%
SAMPLE	
SIZE:	50% of all patients with a refractive error greater than -5.00D in either eye
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Classe JG. Optometrist's duty to detect retinal detachment. In: Legal aspects of optometry. Boston: Butterworths, 1989:324-325.

Alexander LJ. Primary care of the posterior segment. East Norwalk, CN: Appleton & Lange, 1989:176.

Classe JG. Negligence. In: Bartlett JD, Jaanus SD, eds. Clinical ocular pharmacology, 2 ed. Boston: Butterworths, 1989:879.

6. HYPERTENSIVE PATIENTS

INDICATOR:	Hypertensive patients will have the following completed at least annually: a. Dilated fundus examination. b. Fundus photographs of any changes in retinal appearance. c. Referral to the health care provider managing the patient's hypertension if the patient has not been examined within six months or if a sudden change in the patient's health status is detected. d. Referral to ophthalmology, at the optometrist's discretion, for completion of items 'a' and 'b' above.
THRESHOLD:	90%
SAMPLE **SIZE:**	50% of all hypertensive or borderline hypertensive patients
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

7. GLAUCOMA

INDICATOR:	Patients diagnosed with primary open angle glaucoma will be considered receiving comprehensive eye care when the following criteria are met: a. Threshold visual fields measured at least every six months. b. Applanation tonometry measured at least every three months. c. Stereoscopic evaluation of the optic nerve head at least annually. d. Optic nerve head photos completed whenever any change in the optic nerve head is suspected. e. Gonioscopy annually.
THRESHOLD:	90%
SAMPLE SIZE:	50% of the patients with primary open angle glaucoma
FREQUENCY:	Semiannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Anonymous. Preferred practice pattern on primary open-angle glaucoma. American Academy of Ophthalmology, 1989.

8. CUP TO DISC RATIO

INDICATOR:	Patients with a previously undocumented cup to disc ratio greater than 0.5, AND an IOP greater than 17 mmHG will have the following baseline tests completed: a. Stereoscopic observation of the optic nerve head. b. Diagrammatic or photographic documentation of the optic nerve head. c. Measurement of the central visual fields (patient age permitting).
THRESHOLD:	95%
SAMPLE **SIZE:** **FREQUENCY:**	 50% of applicable patients Semiannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Eskridge JB. Ocular hypertension or early undetected glaucoma. J Am Optom Assoc 1987 Sep; 58(9):747-769.

Henry C, Krupin T. Management of ocular hypertension. Ann Ophthalmology 1985; 17:672-674.

9. BASIC LIFE SUPPORT (BLS)

INDICATOR:	Optometrists and eye technicians are trained in Basic Life Support (BLS) and possess current certification.
THRESHOLD:	100%
SAMPLE	
SIZE:	All optometrists and eye technicians
FREQUENCY:	Annually
RESPONSIBILITY:	Chief, Optometry Service

REFERENCES:

HSC Bulletin on Quality Assurance, #7-89, Aug/Sep 89.

10. QUALIFIED FOR PATIENT CARE

INDICATOR:	Optometrists will be considered fully qualified to provide patient care, to include the use of diagnostic pharmaceutical agents, by meeting the following criteria: a. Be a graduate of an accredited school of optometry acceptable to the Surgeon General, possess a current license to practice optometry in the United States, US Territories, or the District of Columbia, and be a graduate of the AMEDD Officer Basic Course. b. Have received clinical privileges from the local command to provide optometric services. c. Have completed at least 15 hours of continuing education during the past calendar year.
THRESHOLD:	100%
SAMPLE **SIZE:** **FREQUENCY:**	 All assigned and attached optometrists Annually
RESPONSIBILITY:	Chief, Optometry Service

REFERENCES:

Army Regulation 611-101.

HSC Bulletin on Quality Assurance, #4-89, May 1989.

ADDITIONAL EXAMPLES OF

INDICATORS, CRITERIA, & THRESHOLDS

These additional examples of indicators, criteria, and thresholds are not included within the MAMC QAP. They are provided as additional examples of possible indicators that could be adapted to your specific clinic.

11. CONTACT LENSES

INDICATOR:	First time soft contact lens wearers not requiring modification of the initial contact lens parameters prior to dismissal for routine follow-up care.
THRESHOLD:	70%
SAMPLE	
SIZE:	50% of the first time contact lens wearers fit in this clinic
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

12. CONTACT LENSES

INDICATOR:	Patients initially fit with contact lenses in this clinic will remain free of allergic reactions to contact lens solutions.
THRESHOLD:	70%
SAMPLE	
SIZE:	50% of the contact lens wearers originally fit with contact lenses in this clinic
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

13. CONTACT LENSES

INDICATOR:	First time extended wear soft contact lens patients will have 5 or more clinic visits before dismissal for routine followup care.
THRESHOLD:	95%
SAMPLE	
SIZE:	50% of the first time soft contact lens wearers fit with extended wear lenses in this clinic
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

14. CONTACT LENSES

INDICATOR:	Contact lens patients originally fit in this clinic will remain free of corneal ulcers.
THRESHOLD:	100%
SAMPLE	
SIZE:	All contact lens wearers originally fit with contact lenses in this clinic
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

15. HYPERTENSIVE PATIENTS

INDICATOR:	Phenylephrine drops will not be administered to hypertensive patients during routine pupillary dilation.
THRESHOLD:	98%
SAMPLE	
SIZE:	100% of the hypertensive and borderline hypertensive patients
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Classe JG. Liability for ophthalmic pharmaceutical agents. In: Legal aspects of optometry. Boston: Butterworths, 1989:354.

16. GLAUCOMA PATIENTS

INDICATOR:	Patients diagnosed with POAG or as a glaucoma suspect will have had gonioscopy completed within the past two years.
THRESHOLD:	98%
SAMPLE **SIZE:** **FREQUENCY:**	 All patients diagnosed with POAG or as a glaucoma suspect Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

17. OCULAR MEDICATIONS

INDICATOR:	Patients prescribed ocular medications will have any known or suspected allergies documented in their records.
THRESHOLD:	98%
SAMPLE	
SIZE:	50% of the patients prescribed ocular medications
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Classe JG. Liability for ophthalmic pharmaceutical agents. In: Legal aspects of optometry. Boston: Butterworths, 1989:354.

18. DIABETIC PATIENTS

INDICATOR:	Diabetic patients will receive an eye examination within a two-year period.
THRESHOLD:	95%
SAMPLE SIZE:	All diabetic and borderline diabetic patients
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

19. STRABISMUS PATIENTS

INDICATOR:	Strabismus patients less than 10 years old will receive a cycloplegic refraction and a dilated fundus exam at least every other year.
THRESHOLD:	90%
SAMPLE SIZE:	50% of the patients less than 10 years of age
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

Classe JG. The eye-opening case of Keir v. United States. J Am Optom Assoc 1989 Jun; 60(6):471-476.

20. ANTERIOR CHAMBER ANGLE EVALUATION

INDICATOR:	Anterior chamber angle measured prior to pupillary dilation.
THRESHOLD:	100%
SAMPLE	
SIZE:	20% of the patients receiving dilated fundus examinations
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

21. BACTERIAL CONJUNCTIVITIS

INDICATOR:	Patients diagnosed with bacterial conjunctivitis will respond to treatment within seven days.
THRESHOLD:	95%
SAMPLE	
SIZE:	50% of the patients diagnosed with bacterial conjunctivitis
FREQUENCY:	Semiannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

22. VISUAL FIELD INTERPRETATION

INDICATOR:	Interpretation of the results of visual field testing will be documented in the patient's medical record with the reviewing optometrist's name, assessment, and plan.
THRESHOLD:	95%
SAMPLE	
SIZE:	50% of the patients receiving visual field testing in the clinic
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

23. NEAR POINT ASTHENOPIA

INDICATOR:	Patients prescribed near point spectacles will have their asthenopic symptoms decrease and/or resolve.
THRESHOLD:	90%
SAMPLE	
SIZE:	50% of the patients with near point asthenopia as a chief complaint
FREQUENCY:	Semiannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

24. SPECTACLE LENS PRESCRIPTION ERRORS

INDICATOR:	Spectacle lenses will not require refabrication.
THRESHOLD:	95%
SAMPLE	
SIZE:	100% of the patients receiving spectacle prescriptions
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

25. FLIGHT PHYSICALS

INDICATOR:	The ocular portions of all flight medical exams will be completed IAW AR 40-501.
THRESHOLD:	95%
SAMPLE	
SIZE:	50% of patients receiving flight medical exams
FREQUENCY:	Triannually
RESPONSIBILITY:	Quality Assurance Monitor

REFERENCES:

DATA COLLECTION GRID

MONTH _____ YEAR _____ INDICATOR: _____ THRESHOLD: _____

PATIENT NAME LAST, FIRST	SSN	DATE	INDICATOR & CRITERIA MET ? YES	NO	DOCTOR	REMARKS
		TOTAL:				
		PERCENTAGE:				

PEER REVIEW RECORD SHEET

PROVIDER:_____

MONTH:_____

REVIEWER:_____

REVIEW DATE:_____

Key: ✓ = Passed Audit 0 = Failed Audit Item or Item Incomplete N/A = Not Applicable or Not Reviewed PATIENT SSN / DATE	Complete Patient Identification	Clinic Stamp & Date	Legible	Provider Stamp & Signature	SOAP Format	Adequate History (Chief Complaint)	Adequate Testing	Assessment Consistent with History & Findings	Treatment Plan Consistent with Assessment	Patient Problem List Updated	COMMENTS: Identify all comments with patient number first. If additional space is needed, use a blank sheet. All "0" entries must be commented upon. Identify clinical deficiencies as: (M) minor or (S) significant
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											

MADIGAN ARMY MEDICAL CENTER
PATIENT SATISFACTION SURVEY - OPTOMETRY CLINIC

The Optometry Clinic is interested in providing the best possible service to our patients. Your name was selected at random from the clinic's appointment records. Your response will help us improve the services we offer and will remain **completely anonymous**. Please be honest. Your true evaluation of the care you received is requested.

Thank you for taking the time to complete this survey.

Please indicate whether you AGREE or DISAGREE with the following statements concerning the Optometry Clinic. (CIRCLE ONE NUMBER FOR EACH STATEMENT.)

	Strongly Agree		Neutral		Strongly Disagree
1) I felt comfortable while in the waiting area.	1	2	3	4	5
2) I was addressed by my correct name and title.	1	2	3	4	5
3) The Optometry Clinic was clean and professional in appearance.	1	2	3	4	5
4) I was treated courteously by the technician.	1	2	3	4	5
5) The technician acted in a professional manner.	1	2	3	4	5
6) The technician was attentive to my comments.	1	2	3	4	5
7) The doctor's conduct was professional.	1	2	3	4	5
8) I felt the doctor listened attentively to me.	1	2	3	4	5
9) My examination was conducted efficiently with little interruption.	1	2	3	4	5
10) I felt the examination was thorough.	1	2	3	4	5
11) The doctor explained my condition so that I understood my problem.	1	2	3	4	5
12) I was treated courteously by the doctor.	1	2	3	4	5
13) I feel my vision/eye problems were solved.	1	2	3	4	5
14) I look forward to using the Optometry Clinic again in the future.	1	2	3	4	5

OVER

15. Please check the status of the person who received the eye appointment. (Check one box only).

[ ] child of active duty service member
[ ] spouse of active duty service member
[ ] active duty service member
[ ] retired service member
[ ] family member of retired service member
[ ] other

16. What particularly *pleased you* about your visit to the Optometry Clinic?

_____

_____

_____

17. What did you like *least* about your visit to the Optometry Clinic?

_____

_____

_____

18. Overall, the quality of health care provided by the Optometry Clinic was?

[ ] excellent
[ ] good
[ ] fair
[ ] poor

COMMENTS: _____

_____

_____

19. What was the name of the doctor who examined you?

DR. _____

[ ] I do not remember.

20. [OPTIONAL] If there is anything about your experience in the Optometry Clinic that you would like to discuss with our staff, please give us your name and telephone number.

_____

THANK YOU FOR YOUR PARTICIPATION

Appendix F (continued)

Tables, Formulas, and Sample Calculations
For Patient Satisfaction Surveys

The following tables, formulas, and sample calculations are taken from HSC Pamphlet 40-7-23, Ambulatory Patient Care - Patient Representative Officer, to assist in determining the number of patients required to be surveyed.

1. **Questionnaire Table** Use the following table to determine how many questionnaires will be used in the total hospital:

Estimated Number of Total Outpatient Clinic Visits a Day*	Maximum Number of Questionnaires to be Given Out
10 - 100	80
101 - 150	108
151 - 250	152
251 - 500	218
501 - 1000	278
1001 - 2000	322
2001 - 4000	350
4001 - 5000	357

*Includes all health clinics whose data is included in the consolidated MEDDAC/MEDCEN Medical Summary Report.

2. **Questionnaire Formulas** Use the following formula to determine how many questionnaires the Optometry Service needs to complete:

$$\frac{\text{Estimated Number of OPTOMETRY Outpatient Clinic Visits a Day}}{\text{Estimated Number of TOTAL HOSPITAL Outpatient Clinic Visits a Day}} \times \text{Maximum Number of Questionnaires to Be Given Out} = \text{Number of Questionnaires to be completed by the Optometry Clinic Annually}$$

3. **Example Calculations**

Total number of MAMC outpatient clinic visits per day: 2,580
Optometry Clinic outpatient clinic visits per day: 88

STEP ONE: Determine the maximum number of questionnaires to be given out by MAMC from the questionnaire table above: 350

Appendix F (continued)

STEP TWO: Calculate the number of questionnaires to be given to the Optometry Clinic using the questionnaire formula above:

(88/2,580) X 350 = 11.9 or 12 questionnaires should be completed annually.

The number of surveys required by HSC Pamphlet 40-7-23 for the Optometry Service is very small. The MAMC Optometry Service has decided to do a patient satisfaction survey at least three times per year to gain a more realistic picture of the care we are providing. Approximately 50 questionnaires will be completed during each survey period for better sampling of the patient population.

HSHJ-CM-O 24 January 1991
Quality Assurance Program

Appendix G

Sample Format - Quality Assurance Committee Minutes

HSHJ-CM-O (Date of Meeting)

MEMORANDUM FOR Chief, Department of Community Medicine, Madigan Army Medical Center, Tacoma, WA 98431-5021

SUBJECT: Minutes of the Optometry Service Quality Assurance Committee

1. The (name of committee) convened at (time) on (date) in the (location) in accordance with (facility) (regulation), (date). State purpose of the meeting. (Example: The purpose of the meeting was to discuss Optometry Service quality assurance, utilization management, and risk management activities).

2. Attendance:

a. Standing membership present or represented.

(Rank, name, branch) (Chairman first line)	(Position title)

Example:

MAJ David Johnson, MS Chairman	Chief, Optometry Service
CPT Robert Milton, MS	Staff Optometrist

b. Standing membership absent or not represented.

(Rank, name, branch) (Reason for absence; if none, so state)	(Position title)

Example:

CPT Bill Sanders, MS	Staff Optometrist (TDY)

Appendix G (continued)

c. Other persons attending (if none, so state).

(Rank, name, branch) (Position title/activity)

Example:

Ms. Bertha Wilson, RN Occupational Health Nurse

3. Statement regarding review/changes/approval of the minutes of the previous meeting. (Example: The minutes of the last meeting, 30 December 1990, were reviewed and approved as written.)

4. Old business: To include review of actions taken on previous recommendations or findings of the committee (from the previous tracking log, if used).

a. Quality Assurance (QA) issues.

Example:

QA Issue #90-3, CUP TO DISC RATIO. (Topics of discussion are highlighted by using uppercase letters and underlining).[4] Of the 73 patients identified during monitoring and evaluation activities in January as meeting the cup to disc indicator, 70 or 95% met the required criteria. Of the 3 records that fell out, only the measurement of the central visual fields was not completed.

CONCLUSION: It was noted that optometrist #3245 had 38 records reviewed, 36 (95%) of which met the established criteria. Optometrist #5648 had 35 records reviewed, 34 (97%) of which met the established criteria. The cup to disc ratio indicator is well above threshold levels and problems initially encountered with QA Issue #90-3 in October, 1990 have been successfully resolved.

RECOMMENDATION: It is the recommendation of the Quality Assurance Monitor and the QAC that this QA issue be CLOSED.

ACTION: The indicator identified in QA Issue #90-3 will be removed from the annual monitoring and evaluation schedule and another indicator will be substituted in its place.

Appendix G (continued)

EVALUATION: Evaluation of the cup to disc indicator will be discontinued.

FOLLOW-UP: No follow-up is indicated for this QA issue.

b. Reevaluation of closed issues/indicators/peer review record audits, etc.

Example:

No previously closed issues were reevaluated.

5. New business: To include assignment of responsibilities for subsequent action required (which will be entered into the current tracking log, if used).

a. Patient care evaluation. (If nothing is reviewed, so state.)

(1) Results of monitoring and evaluation.

Example:

QA Issue #91-1, FAILURE TO DILATE HIGH MYOPES. Of the 55 patients identified during monitoring and evaluation activities in January, 1991 as having myopia of 5.00D or more, 35 or 64% met the criteria of having a dilated fundus exam completed. Of the 20 records that fell out, 14 were not dilated or scheduled for dilation for no documented reason; 6 were not dilated because of chronic health problems and fear of systemic absorption of the ocular medications.

CONCLUSION: It was noted that optometrist #3245 had 30 records reviewed, 2 of which fell out. Optometrist #5648 had 25 records reviewed, 18 of which fell out.

RECOMMENDATION: It is recommended that the Chief, Optometry Service review the indicators and criteria of the monitoring and evaluation process with optometrist #5648.

ACTION: The Quality Assurance Monitor will continue monitoring this indicator on a monthly basis for optometrist #5648 until threshold levels are reached. The Chief, Optometry Service will counsel optometrist #5648 on the importance of the QAP.

Appendix G (continued)

EVALUATION: Evaluation of this indicator will be monthly for optometrist #5648 until threshold levels are reached, then quarterly for all optometrists.

FOLLOW-UP: This issue will be discussed again at the QAC meeting in February, 1991. The Quality Assurance Monitor will leave this QA issue OPEN.

(2) Medical record review.

Example:

CONCLUSIONS: For the month of January, 1991, 60 medical records were reviewed. No administrative deficiencies or significant optometric clinical deficiencies were found. The following minor optometric deficiencies were identified:

(a) Failure to document the patient's entering visual acuity with the habitual spectacle prescription.

(b) Failure to record the near visual acuity with the new bifocal add power.

(c) Failing to include 2 BO prism in the right spectacle lens in the final spectacle prescription. The 2 BO prism was in the patient's habitual spectacle prescription for the last 15 years.

RECOMMENDATIONS: All deficiencies were discussed with the responsible optometrists.

ACTIONS: The patient who failed to receive the correct spectacle prescription was returned to the clinic and given the correct spectacle prescription.

EVALUATION: No pattern to these deficiencies has been established; therefore, monthly peer review record audits will continue as normal.

FOLLOW-UP: Monthly peer record review by the QAC to ensure that quality care continues to be provided.

b. Utilization review. (If nothing is reviewed, so state.) Individually list items reviewed, i.e., workload, drug antibiotic utilization, ancillary services, staffing and equipment, etc.

Appendix G (continued)

Example:

(1) Total number of outpatient clinic visits for the month of January was 650, with Dr Johnson seeing 300 patients and Dr Milton seeing 350. This total is well below normal monthly averages due to the absence of 2 optometrists and 1 technician on TDY. Total number of outpatient clinic visits should increase to normal levels next month when all optometrists and technicians are present for duty.

(2) The shortage of clinic space and recommendations on how to better utilize the available space were discussed. If additional space could be obtained, it would allow Army reserve optometrists a chance to train here and help reduce the patient waiting list. Dr Johnson will check into the possibility of obtaining more space for the Optometry Service and report back to the QAC next meeting.

c. Risk management. (If nothing is reviewed, so state.) Individually list items reviewed, i.e., unusual occurrence reports, morbidity and mortality, adverse patient outcomes.

Example:

No risk management activities were discussed.

d. Credentialing/privileging/competency. (If nothing is reviewed, so state.)

Example:

INCREASED CLINICAL PRIVILEGES. Dr Sanders has requested that his clinical privileges on DA Form 5440-6-R, Delineation of Privileges - Optometry Service, be changed from Category I to Category II.

CONCLUSIONS: Dr Sanders has successfully completed a 100 hour Concentrated Ocular Therapeutic Course and would like to increase the scope of optometric care he is providing with the use of ocular therapeutics. Successful completion of a 100 hour course meets the criteria established by the Chief, Optometry Service for Category II clinical privileges.

Appendix G (continued)

RECOMMENDATIONS: The QAC recommends that the Chief, Optometry Service approve Dr Sander's request for increased clinical privileges.

ACTION: Dr Sander's request will be forwarded to the MAMC Credentials Committee for approval.

EVALUATION: Following approval by the MAMC Credentials Committee, the Quality Assurance Monitor will review the first 20 records of ocular therapeutic use by Dr Sanders to ensure quality care is being provided.

FOLLOW-UP: The Quality Assurance Monitor will monitor the first 20 records of ocular therapeutic use by Dr Sanders. Normal peer review activities will then monitor the quality of patient care throughout the year.

6. Actions pending. (List open items of concern, if none so state).

7. Recommendations: (Matters requiring the attention and action of a subordinate committee, subject committee, or higher committee must be clearly stated).

a. Issues closed. (List QA issues only, explanations of action taken are not required. If no issues were closed, so state).

Example:

QA Issue #90-3 was closed

b. Issues to be followed up. (List QA issues only, explanations are not required. If no issues are to be followed up, so state. If issue is tabled, state the date it will be readdressed).

Example:

QA Issue #91-1 will be monitored, evaluated, and discussed at the next QAC meeting in February.

Appendix G (continued)

8. The next meeting is scheduled for (time and date).

9. The meeting was adjourned at (time).

Encl(s) (Signature block of chairman)
Enclosure Listing
(Tracking Log, if used)
(Others)

(NOTE: Copies of supporting documents will be attached as enclosures and so noted in the minutes).

(Signature block of recorder)

Example:

ROBERT MILTON, OD
Recorder, Quality Assurance Committee

APPROVED:

_____
JOHN R. SMITH, MD
COL, MC
Chief, Dept of Community Medicine

_____
Date

DISTRIBUTION: (as appropriate)

Appendix H

GLOSSARY

appropriateness The extent to which a particular procedure, treatment, test, or service is efficacious and clearly indicated for the patient.

clinical privileges Authorization by the governing body to provide specific patient care and treatment services in the organization, within well-defined limits, based on an individual's license, education, training, experience, competence, and judgment.

credentials review The verification of current licensing, certification, registration, education, training, experience, and current competence.

criteria "yardsticks" used to evaluate indicators against the quality and/or appropriateness of an aspect of care. Criteria define what the optometry service considers to be acceptable appropriateness or quality.

evaluation Analysis of collected, compiled, and organized data pertaining to important aspects of care. Data are compared with predetermined, clinically valid criteria. Variations from the criteria are judged to be justified or unjustified and problems or opportunities to improve care are identified.

indicator A defined, measurable variable used to monitor the quality or appropriateness of an important aspect of patient care. Indicators can be activities, events, occurrences, or outcomes for which data should be collected to allow comparison with the threshold for evaluation related to each indicator. Indicators are often standards of care or practice that include objective clinical criteria based on authoritative sources such as clinical literature and consensus panels.

monitoring The systematic and ongoing collection, compilation, and organization of data pertaining to indicators for the quality and appropriateness of important aspects of care in order that problems or opportunities to improve care can be identified.

peer review An evaluation procedure that assesses the effectiveness and quality of professional care provided by a health care practitioner when reviewed by other practitioners of the same health discipline. Peer review can take place on a routinely scheduled basis to audit medical records for

administrative and clinical deficiencies, or it can occur on as as-needed basis as part of the 10-step monitoring and evaluation process when threshold levels are not achieved.

practitioner activity file (PAF) A peer review working file maintained on each practitioner. Contained within the PAF are the following types of documents: practice profiles, cases of superior care with documentation, cases referred to the credentials committee regarding possible substandard care, malpractice claims filed or settled together with the peer review findings, expiration date of the basic life support certificate, reports on medical records deficiencies, a verified current state license expiration date, date of last clinical privileges reappraisal, etc. The Chief, Optometry Service will use the PAF data in periodic reevaluation and privilege reappraisal.

practitioner credentials file (PCF) A file maintained on each practitioner given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical care. Included within the file are documents obtained in the credentials review, DA Form 4691-R (synopsis of the education and experiential background of each practitioner), and DA Form 5440-6-R (Delineation of Services - Optometry Service).

quality The degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcome for a particular service, procedure, diagnosis, or clinical problem.

thresholds A pre-established level or pattern of performance related to an indicator at which further evaluation of the quality and appropriateness of an important aspect of care is initiated.

Appendix I

REFERENCES

1. Ball, Roy. Quality Assurance Division, Office of the Deputy Chief of Staff for Clinical Services, Health Services Command, Personal Correspondence, 4 Jan 91.

2. Ball, Roy. Quality Assurance Division, Office of the Deputy Chief of Staff for Clinical Services, Health Services Command, Personal Correspondence, 4 Jan 91.

3. Quality Assurance Newsletter, Health Services Command, OCT/NOV 90, p. 4

4. Health Services Command Pamphlet 40-7-23, Ambulatory Patient Care - Patient Representative Officer, 13 Aug 86, p A-2.